Recommendation 2: Twenty-four (24) intensive residential service homes (IRSHs) should be initially identified and/or established in strategic locations by the end of SFY19.

Individuals served in IRSHs should be adults that have a diagnosis of mental illness and may also have an accompanying co-occurring diagnosis of developmental/intellectual disability and/or substance use disorder. The individuals' functional assessment should reflect that the individuals have a serious and persistent mental illness (SPMI) including:

- Having a diagnosis of a serious mental illness (e.g., schizophrenia, schizoaffective disorder, major depression, bipolar disorder, or other serious psychiatric disorder);
- Having three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;
- Needing 24-hour supervised, monitored and focused treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;
- Not being responsive to an adequate trial of active treatment at a less intensive level of care;
- Being at risk of significant functional deterioration if intensive residential services are not received; and
- Having one or more of the following:
    - Three psychiatric hospitalizations in 6 months
    - Greater than 30 medically unnecessary psychiatric hospital days
    - Greater than 90 psychiatric hospital days per one stay
    - Three emergency room visits related to a serious psychiatric diagnosis in 6 months
    - Residing in State Resource Center with a serious psychiatric diagnosis
    - In Jail due to a serious psychiatric diagnosis or, being released from jail or prison with a serious psychiatric diagnosis
    - Precarious housing/ homeless

IRSH provide intensive, 24 hour, seven day a week, 365 day a year, coordinated supported community living services for individuals with the most intensive SPMI described above. Since the skills required to serve different sub-groups of individuals dramatically differ, IRSH should serve a homogeneous group of individuals (e.g., individuals that have similar characteristics such as only an SPMI or an SPMI with intellectual disability, etc.) IRSH services and supports should:

- Have adequate staffing that includes:
    - Appropriate specialty training including applied behavior analysis as appropriate;
    - Adequate direct care staffing ratios (e.g., no more than 2½ individuals served per staff on duty) with opportunities for lower staffing ratios based on demonstrated need; and
    - Swift access to additional staffing when serious incidents occur; and
    - Adequate pay and paid time off commensurate with the increased intensity of the services provided.
- Coordinate with the individuals' clinical mental health and physical health treatment including:

    - Ensuring access to active medication management and outpatient therapy, including evidence based therapy;
    - Establishing a fully coordinated care plan that includes instructions on how to most effectively interact with the individuals served in home and in the community;
    - Accessing Assertive Community Treatment (ACT) if there is a demonstrated need[1]; and
    - Developing a thorough Wellness Recovery Action Plan (WRAP)
- Be licensed to provide substance use disorder treatment or have direct access to licensed substance use disorder treatment for those it serves with a demonstrated need;
- Accept court ordered commitments;
- Have a high tolerance for serious behavioral issues; and
- Not eject or reject individuals referred to them based on the severity of the individuals' mental health and/or co-occurring needs.

IRSHs are the individuals' home. So, IRSHs should preferably be small (e.g., 5 individuals or less) and located in typical neighborhood settings to maximize community integration and natural supports[2]. Larger capacity IRSHs should be rare. In no case should an IRSH be larger than 16 beds.

The individual's length of stay in the program should be determined on an individual basis using person centered planning with the goal to live in the most integrated setting practicable. The individual's status related to housing should be based on the individual's expected length of stay. Individuals expected to stay longer in the home should have the protections of a landlord tenant relationship. Individuals expected to stay shorter periods should not be hampered from moving by a long term lease.

In addition to IRSH, individuals should have opportunities for employment, vocational development, or other valued activities outside of the home.

MCOs and mental health and disability services (MHDS) Regions should jointly select IRSHs. Existing 1915i home and community based services "habilitation homes" that meet IRSH criteria should be considered for selection. MCOs and MHDS Regions should mutually agree on additional IRSH to be developed in strategic geographic locations. MCOs and MHDS Regions should work with the state mental health institutes, Broadlawns, and the University of Iowa Hospital and Clinics, or other interested hospitals with inpatient psychiatric programs to operate or affiliate with one IRSH each as an integral part of their mental health services.

MHDS Regions should be required to provide start-up funding for jointly selected IRSHs that are not yet operating.

---

[1] Recommend Iowa Administrative Code be revised to clearly state that, when there is a demonstrated need, ACT can be provided simultaneously with 1915i Habilitation services.

[2] Housing options need to be compliant with Principles of the Olmstead Ruling, Centers for Medicare and Medicaid (CMS) Settings Rules, and the 16 bed limit related to the CMS institutions for mental disease rules.

MCOs should be required to reimburse efficiently operated IRSHs for the covered Medicaid services the IRSH is enrolled with Medicaid to provide (e.g., home-based habilitation - supported community living) to Medicaid members that have a demonstrable need for the service at a level that allows them to be financially viable. MCOs should offer contracts to jointly selected IRSHs.

MHDS Regions should be required to provide additional funding necessary to keep IRSHs financially viable (e.g., pay for non-Medicaid services that may be needed such as room and board, vacancies, and transportation).